Otsuka
Otsuka America Pharmaceutical, Inc.

OAPI Patient Assistance Program for SAMSCA™ (tolvaptan)

Fax to: 1-866-565-7793

For patients who are uninsured and who need to continue taking SAMSCA following discharge from the hospital, Otsuka America Pharmaceutical, Inc. (OAPI), will provide SAMSCA free of charge to eligible patients. To apply, please fill out all sections of these forms and fax them to 1-866-565-7793. **Be sure to attach copies of all requested information. Incomplete forms will not be processed.**

Date________________ From__________________________ Phone_____________________ Total number of pages sent_____________

Instructions: Fill out all pages completely and fax to the above number. Be sure to include copies of all requested documentation.

Section 1: Physician Information

Facility/hospital name____

Physician name____

DEA No._________________ License No.___________________ NPI No._________________

Physician address____

City____ State______ ZIP_______________

Office phone_______________________ Office fax__________________________________

Contact person_____________________________ Phone______________________________

Section 2: Medical/Prescription Information

Patient name____

Diagnosis____

Date SAMSCA was started in hospital____

Date of discharge_____________________

Serum sodium level at initiation____________ Current level______________

Dose of SAMSCA ❑ 15 mg ❑ 30 mg ❑ 60 mg (two 30-mg tablets) Dosing frequency__________________

Number of tablets__________

Anticipated duration of SAMSCA therapy___________________

Please list any other medications this patient is taking____

I certify that I am prescribing SAMSCA for this patient in a manner that is consistent with the approved labeling.

I agree to the guidelines established by Otsuka America Pharmaceutical, Inc. for the OAPI Patient Assistance Program for SAMSCA, and that I will not bill any federal or private payor for the SAMSCA provided under this program.

I have obtained and maintain a valid HIPAA authorization form for the OAPI Patient Assistance Program for SAMSCA for the above named patient.

Physician signature____ Date_______________________

Please see accompanying FULL PRESCRIBING INFORMATION, including **Boxed WARNING**.

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Section 3: Patient Information

Name____

Address______________________________ City__________ State____ ZIP_______

Note: Patient or caregiver signature required for delivery. Cannot be delivered to PO boxes.

Home phone________________________ Work phone________________________

Date of birth____________________ Social Security number____________________ Are you a legal US resident? Yes___ No___

Insurance Coverage

Do you have prescription drug coverage? Yes___ No___

Are you enrolled in Medicaid? Yes___ No___

If you have a pharmacy discount card or participate in another drug program, this is not considered insurance and you still may be eligible.

Are you enrolled in Medicare Part D? Yes___ No___

Financial Information

I understand that in order to qualify for assistance my adjusted gross income may not be higher than 3 times the federal poverty level for the state in which I live. Please list all sources of total monthly income below and attach a copy of your most recent US income tax return (IRS form 1040, 1040A, 1040EZ, 4506-T, or 1099). Total monthly income includes the gross monthly income of the patient, spouse, and others living in the household. This includes salary, pension, Social Security income, Supplemental Security income (SSI), Social Security disability, and unemployment compensation.

Salary/wages $____________ Social Security $____________ Child support/alimony $____________

Disability $______________ Medical expenses (this may be used to reduce total income) $_____________

Pension/retirement $______________ Unemployment/workers' compensation $________________

Total gross monthly income $________________ Number of people in your household (including yourself)_________

APPLICANT CERTIFICATION

I certify that I am a legal United States resident, earn less than 300% of the current HHS Poverty Guidelines, and that I do not have government or private insurance or benefits that help pay for my prescriptions and I do not have the ability to pay for the Samsca™ (tolvaptan) requested by my physician. I understand that the OAPI Patient Assistance Program ("the Program") and its administrators will use my personal information provided in this application to assess my eligibility for participation in the Program, including contacting me to verify information, my application status and/or receipt of Samsca medication. I understand that OAPI will terminate program assistance, if OAPI becomes aware of any fraud, if Samsca is no longer prescribed for me or if I become ineligible for the Program. I agree to immediately notify the Program, if there are any changes to my financial status, including enrollment in private or government insurance such as a Medicare Part D plan. I understand that OAPI reserves the right to discontinue or change the Program at any time. I also understand that completing this application does not guarantee that I will qualify for assistance under the Program. I certify that the information provided in this application is complete and accurate.

Patient signature____ Date________________

Please see accompanying FULL PRESCRIBING INFORMATION, including **Boxed WARNING**.

OAPI Patient Assistance Program Authorization Form

As may be required by the Health Insurance Portability and Accountability Act of 1996 and related regulations ("HIPAA"), this Patient Assistance Program Authorization Form authorizes your health care provider to disclose your personal health and medical information to Otsuka America Pharmaceutical, Inc. ("OAPI"), its employees, representatives, its affiliated companies, agents, and third party suppliers (collectively, "Recipients") to provide services in connection with the OAPI Patient Assistance Program for SAMSCA™ ("the Program"), and for the Recipients to disclose such information among each other for purposes related to administration and implementation of the Program as further described below.

I,____________________________**[Full Name]** hereby authorize ________________________ **[Name of Physician or Medical Group]** ("Health Care Provider"), to disclose my individually identifiable health and medical information (such as medical condition, prescription drugs used and prescribed), personal information (such as name, address, social security number, insurance coverage) and other information provided by me to the Recipients to determine my eligibility for assistance and to provide services under the Program or otherwise including, but not limited to, complying with applicable U.S. Food and Drug Administration reporting requirements relating to Samsca.

I understand that I may revoke this authorization at any time by providing a written notice of revocation to my Health Care Provider that refers to (or attaches a copy of) this authorization form. If I revoke this authorization, I understand that any disclosures of my personal information will be prohibited after the date the revocation is received and processed but will not affect disclosures made before that time to the Recipients in reliance of this authorization.

I understand that I may refuse to sign this authorization form and that if I refuse to sign, I will not be able to participate in the Program. However, I understand that my decision to decline to sign this authorization form will not affect my ability to get medical treatment from my Health Care Provider, or to seek payment for treatment or affect my insurance enrollment or eligibility for insurance benefits.

I acknowledge that OAPI, its employees, representatives and its affiliated companies are not entities covered by HIPAA and related federal privacy regulations. I understand that once my personal information is disclosed to OAPI and its affiliated companies, federal privacy laws may no longer protect the information from further disclosure. I understand that my protected health information will be kept as private as possible under law.

I understand that I will receive a copy of this authorization. I also understand that unless I revoke this authorization earlier, this authorization will expire at the end of my participation in the Program. After the expiration, I understand and agree that the Recipients may retain my medical and health information and may continue to exchange such information in accordance with this authorization and applicable law.

Patient or Patient's Personal Representative Signature_______________________________Date________________

Patient's Name_______________________________

Name of Personal Representative_______________________________ Relationship to Patient_________________

Health Care Provider has verified Patient Representative's authority to act on Patient's behalf_______(please check)

Health Care Provider must give Patient and/or Patient's Representative a signed copy of this authorization form.

Please see accompanying FULL PRESCRIBING INFORMATION, including **Boxed WARNING**.

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